

# Dreams in Cognitive-Behavioral Therapy

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## Abstract

In recent years, cognitive-behavioral-oriented therapists have found a new interest in work with dreams. Dream analysis within the framework of cognitive-behavioral therapy (CBT) seems to be fully justified if the cognitive processes involved in the dreaming process are considered. The aim of the chapter is to introduce three perspectives for working with dreams within the realm of CBT. The first perspective is dedicated to the historical view on the use of dreams in CBT. The second includes an analysis of the conceptual functions of working with dreams in CBT. The third presents practical issues related to dream analysis in CBT. To sum up, the chapter presents systematic and comprehensive information about the therapeutic work with dreams within CBT from a historical, functional, and processual perspective.

**Keywords:** dreams, cognitive-behavioral therapy, dream analysis, continuous hypothesis, cognitive content-specificity hypothesis

## 1. Introduction

Since the birth of psychotherapy, work with dreams has been mainly developed in the realms of psychoanalysis, psychodynamic therapy, and less commonly within humanistic or existential therapy. Within the framework of cognitive-behavioral therapy (CBT), very few dream analysis concepts have been elaborated on. However, in recent years, cognitive therapists have found a new interest in work with dreams [1].

Referring to dreams in CBT is fully justified if the cognitive processes that are involved in the dreaming process are considered. Dreaming includes such cognitive processes as: accumulating content in both semantic and autobiographical memory; representing these elements in a visual and auditory manner and in other modalities; combining the above representations into a dream scene; creating a narrative sequence for the dream scene; and focusing on dream

content [2]. Dreaming is also related to assimilation of personal experiences into one's existing memory system. During this process, waking life events are contextualized through the formation of connections between previous cognitive and emotional experiences and present circumstances [3]. Dreams are one way of assimilating waking experiences into the schemata because they help to classify emotional experiences from the waking state, compare them with memories, and plan future actions [4]. These processes are possible in the case of dreams that do not reflect powerful emotional traumatic events. Such dreams (usually nightmares) are very likely to be recurrent, as they are an attempt to complete the assimilation of negative waking experiences [3, 4].

Treatment of recurrent frightening dreams within the framework of CBT is well elaborated [5]. This topic has been addressed in other reviews and meta-analyses [5–7]. Working with nightmares in CBT is developed and often applied, but working with dreams, in general, in CBT is barely elaborated and rarely used. A vicious circle occurs due to a lack of research on the use of dreams in CBT, and there is a very little knowledge about dream analysis in this therapeutic approach; therefore, therapists do not want to elaborate on this topic during therapy sessions [2, 8].

The main aim of the chapter is to present perspectives on working with dreams within the framework of CBT. The first perspective concerns the historical view on the usage of dreams in CBT. The second functional perspective includes an analysis of the conceptual functions of working with dreams in CBT. Finally, yet importantly, the processual perspective is focused on practical issues related to working with dreams in CBT.

## **2. A historical perspective on working with dreams in CBT**

The main aim of this part is to introduce a historical perspective on dream analysis within the framework of CBT. A division into objective and constructive approaches toward dream work in this approach is distinguished. The first comes from the objectivist tradition in CBT and is represented by, among others, Beck and Freeman. The second is more focused on metaphorical, subjective, and affective ways of understanding dreams. To this approach belongs, for instance, Hill [4]. Differentiation of dream analysis orientations in CBT is worth mentioning, although we concentrate on various propositions of working with dreams without reference to this division.

The historical perspective on dream analysis in CBT concerns the works of Beck [9], Hill [4], Freeman [8], and Montangero [2]. The use of dreams in third wave schema therapy is also considered. However, the aforementioned authors are not the only ones who have developed the topic of dream analysis in CBT. Others include Gonçalves and Barbosa [10], and Barrett [11]. Due to lack of space and the assumption that the historical perspective is only one part of the chapter, a presentation of all of these concepts is beyond the scope of this review.

### **2.1. Aaron T. Beck: from psychoanalysis to a cognitive approach**

Aaron Beck is one of the founding fathers of CBT. Before he made a pioneering contribution to this therapeutic approach, he was trained in psychoanalysis. In 1959, he joined the research

group led by Saul [12]. The main goal of their project was to examine the psychoanalytical theory of “inverted hostility” in depressed patients [13]. This concept assumes that a self-punitive need to suffer occurs in depression [14]. It was suggested that “masochistic” dreams are related to depression and that subjects with masochistic tendencies might be more prone to this disorder, so the study confirmed the psychoanalytical concept of “inverted hostility” [13]. In fact, this is the only article by Beck in which he referred to psychoanalytical interpretation of dreams.

In his next project, Beck, in collaboration with Ward, extended the research and confirmed his previous findings [15]. In discussion, he assumed that: (a) it is not necessary to analyze dreams, or assume any unconscious meaning, to assess their thematic significance; (b) the manifest dream content correlates well with important themes in a person’s waking life; (c) the themes of a person’s pathology and of his or her will correlate, suggesting the existence of a certain mechanism that regulates how we construct meaning; and (d) systematic and experimental study of dreams would be useful in isolating other thematic correlates of specific psychopathologies and pinpointing their mechanisms [14].

The aforementioned conclusions were fundamental for a cognitive shift of Beck’s thinking about the mechanisms of mental disorders. Along with Beck’s personal disappointment with the results of his own psychoanalytical therapy and his dissatisfaction with how psychoanalytical therapists treated their patients, his conclusions on dreams led him to abandon psychoanalysis and motivated him to work on his own therapeutic method [12]. In 1971, Beck published his last paper on dreams; this was the only one that concerned dreams and a cognitive approach [9]. In this article, he defined dreams as “(...) a visual phenomenon occurring during sleep” [9]. According to Beck [9], dreams reflect the patient’s concept of the self, the world, and the future. Consequently, dreams are seen as reflecting a patient’s cognitive patterns, which are specific to the individual and “exert a maximum influence on the content of dreams” [9]. Therefore, some dreams can be a useful tool in cognitive restructuring as they help reveal cognitive distortions, schemas, and maladaptive thought patterns.

Moreover, according to Beck [9], a single dream may provide a clarification of the patient’s problem. After formulating a series of alternative hypotheses, a dream can support one of them, modify them, or offer completely different possibilities. Dreams might also be considered as a kind of biopsy of the patient’s psychological processes. Pathognomonic dreams show, in turn, the way the individual sees himself, the world, and the future. Dream content may reflect changes in waking cognition due to progress in therapy [16].

Beck, at the beginning of his academic and therapeutic carrier, was deeply interested in dreams. After he established the basis of cognitive therapy, he wanted to spread his ideas. He was frustrated with the psychoanalytic politics of personal loyalty and in turn, psychoanalytic therapists were not interested in contributing to the “broad psychotherapy” postulated by Beck. Therefore, he turned toward behavioral therapists, who offered him a supportive community and opportunities for bringing cognitive therapy to a wider audience [17]. This alliance with behavioral therapists forced him to abandon his research on dreams. Subsequently, due to ideological, financial, and pragmatic reasons, Beck, decided not to continue his interest in dreams. CBT still bears the consequences of this decision: until now, working with dreams has been neither well implemented nor well researched. Freeman and White [8] pointed out

other factors that may influence the fact that cognitive-behavioral therapists do not consider dreams as important: lack of training in the use of dreams in CBT, lack of a manual dedicated to dream work in this approach, and regarding dreams as unconscious or having no direct behavior component. Despite these reasons for the lack of interest in dreams in CBT, a few methods and guidelines for using dreams in this therapeutic approach have been developed.

## 2.2. Clara E. Hill: the cognitive-experimental model of dream interpretation

One of the most elaborated and well-documented method of working with dreams in psychotherapy sessions is Hill's cognitive-experimental model of dream interpretation. It was developed in the 1990s based on psychoanalytic, existential-phenomenological, gestalt, cognitive, and behavioral approaches [4]. Due to the variety of sources of Hill's model, it is not directly recognized as a part of CBT. However, it can be used within CBT as an integration model that applies to Beck's concept of cognitive therapy as integrative therapy [18, 19]. This method is broadly presented elsewhere [4, 20].

According to Hill [4], dreams are a continuation of waking thoughts and therefore their meaning is personal. They contain cognitive, behavioral, and emotional components. Working with dreams assumes collaboration between the therapist and the client,<sup>1</sup> who is the main figure in this process. The goal of working with dreams is to introduce changes in the way clients think, feel and behave, and to develop their self-understanding [4].

The cognitive-experimental model of dream interpretation comprises the three following stages: (a) exploration, (b) insight, and (c) action. The first stage, consists of five steps: (a) explaining the model; (b) re-telling the dream; (c) exploring overall feelings and the timing of the dream; (d) exploring images according to DRAW method (description, re-experiencing, associations, waking life triggers); and (e) summarizing [20]. During the exploration stage, the client has an opportunity to reveal relationships between the dream and waking life [4, 20].

When dream images have been explored, the insight stage is introduced. It is divided into three steps: (a) asking the client for an initial understanding of the dream; (b) establishing the meaning of the dream; and (c) summarizing [20]. During this stage, the therapist and the client collaborate to establish the meaning of the dream [4].

The action stage has three steps: (a) changing the dream; (b) encouraging the client to make changes in his/her waking life; and (c) summarizing. Changing the dream may refer to the therapist asking the client to alter the dream in his/her imagination or create a continuation of the dream. The therapist encourages the client to think about ways in which he/she would like to change the dream plot. Hill [20] describes three possible kinds of actions: (a) behavioral changes; (b) rituals, and (c) continued work on the dream. In this stage, the therapist can also teach the client new ways of behavior, or encourage her/him to use skills she/he has already but is afraid to put into practice [4].

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<sup>1</sup>Hill [4] uses term "client" instead of "patient." We follow this nomenclature to describe the cognitive-experimental model of dream interpretation; however, in all chapters we decided to use term "patient" in order to simplify the nomenclature.

### **2.3. Jacques Montangero: the description, memory sources, and reformulation method**

Montangero claims that “dreaming is a primarily cognitive phenomenon since it consists of creating representations, that is, evoking things that are absent by means of substitutes like mental images, words, etc.” [21]. Dream representations are not meaningless; they are related to a person’s aspirations and concerns and they are often complementary to topics from the preceding day that one does not want to or has no time to think about. Therefore, the meaning of dreams is not univocal, but personal [21].

The goal of the systematic procedure of dream interpretation developed by Montangero [2] is to reveal this personal meaning of dream elements. The description, memory sources, and reformulation method (DMR) was elaborated in the 1980s and improved until the early 2000s [21]. The method has three steps: (a) complete description, (b) search for mnemonic sources, and (c) reformulating the dream description.

In the first step, the patient has to immerse in the memory of his/her dream. He/she shares the dream content with the therapist, who writes down this description. The second step is focused on connecting the dream elements to autobiographical memories in order to clarify the meaning of the dream. The aim of the third step is to describe the dream content as a sequence of more general terms. The patient and therapist collaboratively categorize and find a definition or function for each element of the dream. These general ideas could later be applied to the patient’s aspirations or concerns. Reformulation of the dream leads to its interpretation, which is based on relationships between dream elements and waking experiences of the patient [2, 21].

Montangero established the DRM method as a part of CBT as it has several general methodological principles in common with this approach; for instance, both the DRM and CBT use a systematic analysis of the mental content of the patient [21]. We were unable to find any empirical research on this model.

### **2.4. Arthur Freeman: guidelines for using dreams**

According to Freeman, a dream is a representation of an idiosyncratic dramatization of the dreamer’s view of the self and the world. It reflects the waking cognitions and affective responses of the individual, not the “mysterious reflections of so-called deeper issues” [8]. Appealing to dream symbols should also be avoided; hence, in therapy, a dream should be understood in terms of the patient’s life and his/her experiences from waking states [8].

Arthur Freeman has been working on dream analysis in CBT since the 1980s [8, 22, 23]. He had to rely on Beck’s early papers because in other sources he failed to find any references to dreams, dreaming, or the use of dreams in CBT [14]. He listed points concerning “cognitive dream interpretation.” The most recent version contains rules as, for instance: understand the dream in thematic rather than symbolic terms; the thematic content is idiosyncratic to the dreamer and must be understood within the context of his/her waking life; the affective responses to the dream image can be seen as similar to the emotional responses of the patient in waking life; dream content and images come under the same cognitive restructuring methods as automatic thoughts; the dream may reflect the patient’s schema. The complete version is described elsewhere [8].



These guidelines simply and accurately present how cognitive-behavioral therapists can work with dreams within this therapeutic approach.

### **2.5. Jeffrey Young: schema therapy and dreams**

Schema therapy is an integrative therapy that significantly expands on traditional CBT. It was developed by Young and colleagues in 1990. One of the main assumptions of schema therapy states that schemas, which have their source in toxic childhood experiences, might be the core of a number of psychological problems. Such schemas were labeled as early maladaptive schemas; these are defined as a broad, pervasive theme or pattern comprised of memories, emotions, cognitions and body sensations regarding oneself and one's relationships with others that was developed during childhood or adolescence and elaborated throughout one's lifetime and is dysfunctional to a significant degree (for more, see: [24, 25]).

Two phases of schema therapy were established: (a) the assessment and education phase and (b) the change phase. According to Young [24], schema therapy can refer to dreams in both stages. Schemas are triggered during various experiences during a patient's life; they can be present not only in waking mentation, but also in dreams. Recurrent dreams and those with strong affect are most important. A patient can record his/her dreams and discuss them with the therapist. Dream content can reveal a patient's schemas in the first stage of schema assessment. Furthermore, recounting a dream can be a starting point for imagery work related to usage of experiential methods in the schema change phase [24].

The aforementioned tips for working with dreams in schema therapy are the only ones that have been formulated so far. Empirical research on working with dreams in the third wave of CBT is still lacking.

## **3. A functional perspective on working with dreams in CBT**

Dreams can be useful in psychotherapy. Some approaches, like psychoanalysis, actively apply to dreams, whereas others, like CBT, leave them on the periphery of therapeutic work. Eudell-Simmons and Hilsenroth [26] defined four conceptual functions of dreams in psychotherapy. A detailed description of the methodological issues and the basis of this division are available in the original paper [26]. Due to the scope of the chapter, we focus on the functions of dreams in terms of CBT.

### **3.1. Facilitating the therapeutic process**

Working with dreams in therapy can facilitate the therapeutic process in these ways: increasing patient disclosure and comfort; improving his/her attitude toward the therapeutic process and participation in therapy; encouraging his/her engagement and positive involvement in therapy; and enhancing the cooperation and the working alliance between patient and therapist [26]. Moreover, use of dreams can prevent patients terminating therapeutic treatment early [27].

The therapeutic process in CBT includes several components: (a) defining the goal of the therapy; (b) elaborating the ever-evolving case formulation of the patient and his/her problems in

cognitive terms; (c) emphasizing the present in the first phase of therapy; (d) structuring the therapeutic process and every therapeutic session; (e) establishing a good patient-therapist relationship; (f) collaboration between the patient and the therapist and the active participation of both in the therapeutic process; (g) emphasizing the role of psychoeducation; (h) using a variety of techniques to change thinking patterns, mood, and behavior of the patient; and (i) limiting the number of sessions [28].

Including work with dreams during each of these steps is plausible if: (a) the goal of the therapy can be defined, for instance, as the changing of an unpleasant dream, or decreasing the negative emotions related to the dream; (b) information obtained from dream content can be incorporated into the case formulation of the patient; (c) in the initial phase of therapy, the patient and the therapist can focus on the last dream or unpleasant/important dreams as the basis for extension of their therapeutic work; (d) working with dreams can be planned within the whole course of therapy; (e) working with dreams can facilitate the therapeutic relationship [26]; (f) the methods of dream analysis require collaboration between the patient and the therapist and their active participation in the process of dream interpretation; (g) information about the process of dreaming and sleeping can be a part of psychoeducation; (h) a variety of standard CBT techniques can be used to work with dreams; and (i) the patient and the therapist can establish the amount of time devoted to working with dreams in each session, as well the entire therapeutic process.

According to Safran et al. [29], a good therapeutic relationship in CBT consists of: (a) interpersonal processes, (b) alliance ruptures, and (c) the patient's emotions. Effective collaboration between the patient and the therapist increases the chances of therapeutic change and the healing of dysfunctional schemas. Schemas can be also present in dreams and work on dream content can facilitate modification of these unhelpful schemas [24]. For patients who have problems in establishing a good collaborative relationship with the therapist, the recounting of dreams may help to develop trust in the therapist more quickly and deeply. Working with dreams can also encourage the patient to introduce and/or pursue issues that otherwise may have been too difficult, painful, or embarrassing to discuss with the therapist [13]. Hence, elaborating on dreams can positively influence the interpersonal processes between the patient and the therapist [28]. There is a variety of methods for dealing with difficulties in therapy, one of which is to refer to dreams [26]. Finally, yet importantly, the patient's emotional arousal is necessary for the therapeutic progress [28]. Some dreams have a great emotional impact; therefore, working with them can be useful when processing the patient's difficult experiences in the course of therapy [30].

Dream analysis can bring multi-faceted support to the therapeutic process. As indicated, work with dreams can be incorporated into each element of the therapeutic process in CBT. However, this is a theoretical analysis that needs to be verified in empirical studies.

### **3.2. Facilitating self-knowledge of the patient**

One of the goals of therapy is to enhance self-awareness or self-knowledge of the patient. Alternatively, it is called insight, understanding, or recognition [26]. Although, the term "insight" is traditionally not used within CBT, the process of fostering self-awareness of the patient is important [31].

In the course of CBT, the patient generally has two opportunities to gain new self-knowledge. Firstly, within collaborative empiricism, which involves a systematic process of the patient and the therapist working together [32], the patient's dysfunctional thoughts, beliefs, schemas, and coping strategies are identified [28]. Secondly, during psychoeducation, the therapist provides important information about the mechanisms of disorders, relapse prevention, and so on for the patient [28].

The patient extends his/her self-understanding when discussing his/her waking mental content with the therapist. However, dreams can also be a source of self-knowledge [26]. With reference to CBT, dreams may contain information about cognitive patterns [9], schemas [24], and cognitive distortions [2]. Dreams can also bring forth information about a patient's feelings toward various situations and experiences.

Individual's dreams can contribute to therapy by increasing the self-knowledge of the patient. The information obtained from discussing dreams can potentially lead the patient to greater self-understanding. Moreover, they can enhance the patient's motivation for therapy and provide the knowledge needed to change dysfunctional cognitive and behavioral patterns [26].

### **3.3. Providing clinical information for the therapist**

The therapist needs information about the patient to plan the therapeutic process and interventions adequately. The first phase of CBT includes individual case formulation and clinical diagnosis. In CBT, several ways of obtaining information about the patient are possible, for instance, clinical interview, and self-observational methods [28]. An additional way of gaining information about the patient is to ask him/her about his/her dream content [26].

The approach of finding relationships between dreaming and waking experiences, which is typical of the therapeutic setting, starts with a dream and goes into its connections with the waking-life issues of the patient. Studies on dreams in psychodynamic therapy have shown that they provide information about, among others, patient's patterns of interpersonal functioning, his/her personality structure, and images of self and others. Dreams can also reveal information the patient is not aware of, for instance, his/her attitude toward the therapist [26, 33]. Important information for the therapist in CBT that may be provided by dreams concerns the patient's cognitive patterns [9], core beliefs [2], schemas [24], cognitive distortions [2], patterns of behaviors [15], patterns of affective responses [23], and resources [2].

Often dreams quickly and efficiently reveal information that is unique to the patient, especially information that the patient is not aware of or just does not want to share with the therapist. When the specialist recognizes this information, he/she can help the patient perceive it and subsequently change maladaptive cognitive and behavioral patterns. Dreams can also contain crucial information about a patient's emotions [26].

Dreams can reveal much important information about the patient to the therapist. Working with dreams in therapy may facilitate the speed at which some personal material is introduced to collaborative therapeutic discussion, helps the patient recognize and express emotions and thoughts, and may even shorten therapy [26]. However, there is no research on this use of dreams related to providing clinical information to the therapist in CBT.



### **3.4. Providing a measure of therapeutic change**

The last conceptual use of dreams in therapy refers to using dreams as a measure of therapeutic change. Dreams can provide information about the patient's functioning outside of therapy and indicate therapeutic change or improvement of the patient due to therapy [26].

Changes in dream content can occur not only when the therapeutic goal assumes working on dreams, but also when other goals, even those not related to dreams, have been accomplished. A shift in a dream can indicate that clinical improvement in relation to personality development and behavioral change has been achieved [26]. Interestingly, the anxiety content of dreams increases in patients who are successful in therapy. This possibly reflects an increase in tolerance and ability to cope with anxiety when awake [34]. These findings need to be examined in terms of CBT. However, even now it is recommended for therapists to bear in mind that an increasing level of anxiety in dreams may, paradoxically, not be a sign of worsening, but of improvement. Notwithstanding, the decision concerning whether an increasing level of anxiety in dreams is positive or not should be always be based on the broader context of the patient's functioning in the waking state.

Overall, dreams have the potential to indicate therapeutic change. In CBT, this way of evaluation of improvement may be additional to other methods, such as scales. Research on the mechanisms and directions related to therapeutic change and dreams needs to be conducted within the framework of CBT.

## **4. A processual perspective on working with dreams in CBT**

The processual perspective on dreams in CBT is focused on some practical aspects of working with dreams in the course of therapy. There is hardly any research on dreams in CBT and only a few theoretical papers.

### **4.1. Characteristics of patients and therapists who work with dreams**

Therapists who participate in studies on working with dreams in therapy are mainly oriented toward psychoanalytic and psychodynamic approaches. This is related to the fact that dream theories and manuals for dream analysis have seldom been available in other therapeutic approaches, including CBT [35]. Systematic research on the frequency of use of dreams in psychotherapeutic practice, especially CBT, is scarce.

Schredl and colleagues [35] checked the frequency of use of dreams in 79 therapists with private practices. The results revealed that in about 28% of therapy sessions, the topic of dreams is discussed. Therapists had introduced work with dreams in 33% of cases. Schredl et al. [35] divided the total sample of therapists into two categories: (a) psychoanalysts and (b) humanistic and cognitive-behavioral therapist. Compared to humanistic and cognitive-behavioral therapists, psychoanalysts more often refer to dreams, regard work on dreams as more beneficial for patients, and report the greater enhancement of dream recall in patients. Representatives of psychoanalysis have also read more literature about dreams, and more

often work with their own dreams in comparison to humanistic and cognitive-behavioral therapists. The findings indicate that working with dreams in therapy still plays an important role and is considered beneficial in the therapeutic success [35]. In CBT, the literature about dreams is still lacking; therefore, cognitive-behavioral therapists possibly less often work with their own dreams and less willingly develop dream-related issues during therapeutic sessions.

In a study conducted by Cook and Hill [36], 129 therapists rated themselves on a 5-point Likert scale as adhering to techniques of cognitive, humanistic, and psychodynamic approaches on averages of 3.92, 3.26, and 3.08, respectively. Almost all of them (92%) worked with dreams during therapy sessions at least occasionally. Therapists reported that they felt moderately competent or even incompetent when working on dreams in therapy and had moderate or no training in dream work. Such training was strongly related to the aforementioned feelings of competence. Additionally, therapists with more training were likely to devote more time in therapy to work with patients' dreams than were therapists with less training. It seems that training in dream work and therapists' personal experiences with dreams are related to their willingness to elaborate on dreams during therapy sessions [36].

To conclude, cognitive-behavioral therapists have little or no training on working with dreams in therapy. During such training, therapists can gain knowledge about techniques and methods dedicated to work with dreams; therefore, when patients introduce their dreams into therapy, therapists have some idea of how to elaborate on this clinical, narrative material [36]. Lack of knowledge about working with dreams during therapy sessions discourages cognitive-behavioral therapists from discussing dreams with their patients; however, they are somehow more willing to explore dreams in terms of patients' waking experiences than to interpret them [37]. A comprehensive manual concern working with dreams in CBT is needed, as it has not yet been elaborated on.

As the proverb says, it takes two to tango; therefore, there are not only therapists who are open to work with dreams in therapy, but also patients. Patients who remember their dreams more often bring them to therapy than those who do not [26]. Patients who have "thin boundaries" are also more likely to discuss their dreams during therapy sessions [38]. Moreover, patients who have more vivid or memorable dreams and are more attuned to their inner experiences tend to bring dreams to therapy more often than those without these traits [26].

A study on 336 undergraduate students revealed that those who volunteered in a dream interpretation session ( $N = 109$ ) had a more positive attitude toward dreams, recalled dreams more frequently, were more open, were higher in absorption, and were more often female than the non-volunteers [39]. A study on 157 voluntary participants revealed that those who profited most from discussing dreams during therapy sessions had poor initial functioning related to the problem reflected in the dream, a positive attitude toward dreams, salient dreams, low initial insight into the dream, and poor initial action ideas related to the dream [40]. The importance of attitude toward dreams, understood as an indicator of motivation to work with dreams and willingness to bring dream content in therapy [41], is also confirmed in other studies [42, 43].

The therapists' encouragement to talk about dreams in therapy is an important factor when considering bringing dream content into therapy sessions [43]. A vast majority of cognitive-behavioral therapists have not been trained to work with dreams in therapy; therefore, they do not feel competent to discuss such issues. There are studies on the characteristics of therapists and patients who work with dreams in therapy, but no such studies have been conducted directly in CBT.

## 4.2. Phases of CBT

The three phases of the CBT process are distinguished: (a) clinical diagnosis and case formulation; (b) realization of therapeutic goals; and (c) evaluation and preservation of therapeutic achievements [29]. Our proposition to work with dreams within all these stages is presented.

### 4.2.1. *The first phase: clinical diagnosis and case formulation*

The first phase of CBT usually takes a few sessions. It is a very important part of the whole therapeutic process because decisions concerning the treatment plan and clinical interventions are made at this stage [28]. During diagnosis, the therapist can broaden the standard clinical interview with questions concerning dreams; for instance, he/she can ask the patient about the last remembered dream, the most important dream, recurrent dreams, the emotional tone of one's dreams, or the patient's attitude toward dreams.

Beside the standard clinical interview, the therapist can also adopt the dream interview model (DIM) elaborated by Delaney [44]. It is based on the assumption that dream images are symbols or metaphors representing waking experiences of the patient. It can be used as a separate method of dream interpretation; however, the initial steps can also especially be used in the first phase of CBT as a technique that facilitates the process of obtaining information about the patient and his/her dreams. DIM is not dedicated to CBT, but it can be used within this approach due to the integrative assumptions of CBT made by Beck and Alford [18, 19]. DIM is described in detail elsewhere [44]. It may be used within CBT as a method of gaining information about a dream, the patient's feelings and opinions about that dream, and relationships between dream images and his/her waking experiences. Importantly, clinical diagnosis cannot be based on only dreams. Information related to dreams may only be additional information for the therapist to understand the patient better.

If needed, it is plausible to use questionnaires and scales about dreams in a clinical context. However, it is important to remember that these tools were developed for scientific research and therefore should be used with caution in therapy. Some methods are available to assess attitudes toward dreams: the attitude toward dreams questionnaire [39, 43], and the attitude toward dreams scale [45]. In the course of therapy, the dream recall frequency scale may also be useful [46]. Other methods may be used during clinical diagnosis, for instance the dream questionnaire [47], and the Mannheim dream questionnaire [48].

Information about the patient obtained from clinical interviews and other methods serves in CBT to create a case formulation which is "a hypothesis about the psychological mechanisms and other factors that are causing and maintaining all of a particular patient's disorders and

problems” [49]. The case formulation includes, among others, the automatic thoughts, beliefs and schemas, cognitive distortions, typical patterns of behavioral and emotional responses of the patient. This cognitive content may represent both waking and dreaming cognition. As stated earlier, dreams can reveal information about the patient’s core beliefs [2], schemas [24], cognitive distortions [2], patterns of behaviors [15], and patterns of affective responses [23]. All these elements may be incorporated into the case formulation for a better understanding of the patient and the mechanisms behinds his/her problems. Dreams can reveal information that the patient is not aware of or does not currently want to share with the therapist [13].

It seems that dreams may be useful at this stage of CBT in terms of direct and indirect disclosure of information. In this approach, the most important issue is what the patient thinks about his/her own dream, what emotions it evokes in him/her, and what conclusions he/she can draw from it. Research on the use of information obtained from dreams in a case formulation needs to be conducted in the future.

#### *4.2.2. The second phase: realization of therapeutic goals*

The second phase of the CBT process is focused on the realization of therapeutic goals. It aims to improve the functioning and quality of life of the patient. This improvement is achieved with specific therapeutic interventions resulting from the case formulation. During this stage, a variety of techniques focused on cognitive, behavioral, and emotional changes is used [28].

Before focusing on CBT methods that can be helpful when working with dreams, it is worth discussing the relationship between the continuity hypothesis [50] and the cognitive content-specificity hypothesis [51]. The continuity hypothesis formulated by Hall [50] states that “dreams are continuous with waking life.” In dreams, the same personalities with the same characteristics, beliefs, convictions, wishes, and fears are presented as in the waking state [50]. The continuity hypothesis is broadly discussed and studied [52, 53]. The cognitive content-specificity hypothesis, which is a component of Beck’s cognitive theory, states that psychopathological symptoms can be differentiated on the basis of their unique cognitive content, such as automatic thoughts and/or beliefs [50]. This hypothesis is also studied [54]. If these two hypotheses are combined, the conclusion may be that dream content in individuals with diagnosis of specific psychiatric disorders may be continuous with the cognitive content from their waking state. Dreams of patients diagnosed with various psychiatric disorders are continuous with some aspects of their waking life. On the other hand, dreams also reveal several discontinuities from their waking experiences [53]. Research on the relationship between waking/dreaming experiences and cognitive and emotional patterns has still not gone deep enough. A detailed review on dream content in specific groups of patients is not possible in the chapter but in **Table 1**, a compilation of results concerning cognitive content and dream content in selected psychiatric disorders is presented. Due to the fact that results on the relationship between waking and dream cognitive content are still insufficient, the summary below should be taken with caution and treated as additional information, not as the basis for diagnose or clinical interventions. However, as with automatic thoughts and beliefs, dream content can be discussed during therapeutic sessions; therefore, knowledge about relatively frequent dreams in specific psychiatric conditions may be useful for cognitive-behavioral therapists.



Disorder	Cognitive specificity	Dream content (in comparison to the non-clinical population)
Depression	Negative assessment of self, the world and the future (Beck's Negative Cognitive Triad) [22]	Higher rate of nightmares [55]; more negative mood tone (not confirmed in all studies [53]); more passive role of the dreamer [56]
Anxiety disorders	Focus on physical or psychological threats [28]	Anticipation of physical harm and psychological trauma; less friendly interactions with other dream characters [53]
Eating disorders	Excessive focus on issues related to eating, appearance, weight and body shape [57]	More dreams of food (or food rejection) and body distortions [53]
Borderline personality disorder	The world and other people are dangerous and malevolent; the self is powerless, vulnerable, and inherently unacceptable [58]	More distressing dreams that may portray traumatic childhood experiences and main emotional and interpersonal concerns of patients [53]

**Table 1.** A comparison of cognitive specificity and dream content in selected psychiatric disorders.

One of the most basic CBT methods which is also classified as a therapeutic approach within the framework of CBT is cognitive restructuring. Dreams may facilitate this process [2]. The reformulation of dream content has the same structure as working with automatic thoughts. The goal of this intervention is to change dysfunctional themes of dreams and their affective impact by appropriate disputation and rational challenges to maladaptive dream material [8]. Moreover, when working with dreams in therapy, metaphors can be useful [59].

Dream content, the same as automatic thoughts, can be recorded within the homework and then be a part of the therapeutic work during the session. Two reporting techniques are used in relation to dreams: the Dream Log and the Dream Analysis Record [18, 19].

Importantly, in therapy it is possible to work not only on individual dreams, but also on series of dreams. Dream series can provide a lot of information about the patient and reflect changes in his/her state of mind and progress in therapy. Moreover, they can reveal repetitive dream elements which may be clinically important [42]. If the patient and the therapist want to work on dreams during therapy sessions, it is recommended to look at more than just one dream.

#### *4.2.3. The third phase: evaluation and preservation of therapeutic achievements*

The goal of the therapeutic process in CBT is to change the maladaptive and unhelpful cognitive, emotional, and behavioral patterns of the patient, as well as to teach him/her to be their own therapist. The last stage of CBT is aimed at a summary of these changes, re-evaluation of the therapeutic goals established at the beginning of the therapy, and relapse prevention [28].

Working with dreams in therapy is beneficial when it leads to changes in the patient's emotions, cognitions, and/or behavior. These changes may be related to the patient's dreams or to his/her waking life generally. The therapist and the patient can explore how changes related to dreams may be applied to his/her waking concerns [4, 42]. During the last stage of CBT, the therapist and the patient summarize what was helpful for the patient, which

methods were the most useful, what he/she has learned, his/her new adaptive thoughts and beliefs, and what he/she can do when there is a risk of the problem reoccurring [28]. All these interventions can also be used in the case of dreams. The methods of working with dreams, the main conclusions drawn from dreams, and the useful materials about dreams that the patient can refer to after therapy should be mentioned during the last therapeutic sessions.

## 5. Conclusions

The goal of this chapter was to present the historical, functional, and processual perspectives on working on dreams in CBT. Issues related to dreams are rarely raised during therapeutic sessions in this therapeutic approach. Although research on dreams had an important place when cognitive therapy was established by Beck, ideological, financial, and pragmatic reasons led to its abandonment. Only a few methods related to dreams have been elaborated within CBT, for instance the DMR method of dream interpretation created by Montangero [2] and the guidelines for using dreams defined by Freeman and White [8]. There are very few studies on them; the only exception is the cognitive-experimental model of dream interpretation established by Hill [4]. This model has great empirical support; however, it is not dedicated to CBT. Because of the lack of research on the use of dreams in CBT, cognitive-behavioral therapists are not trained in this area and therefore do not work with their patients' dreams. This vicious circle should be broken by conducting empirical studies about the use of dream analysis in the course of CBT, creating manuals for work with dreams, as well as training programs for therapists about such work. As has been presented, working with dreams in CBT can be useful and beneficial when elaborating on the functional perspective. Dreams can not only facilitate the therapeutic process, but also broaden the self-knowledge of the patient, provide clinical information for the therapist, and be a measure of therapeutic change [26]. Dream analysis can be incorporated into all of the stages of CBT. It is possible to refer to it during clinical diagnosis and case formulation, realization of therapeutic goals, and evaluation and preservation of therapeutic achievements. For dream content, the same methods as for working with automatic thoughts can be used. There is potential for dream analysis within CBT; however, this area is still waiting to be explored by cognitive-behavioral therapists, their patients, and researchers interested in CBT and dreams.

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